

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00173810.</p> <p>Complaint IN00173810-Substantiated. State deficiencies related to the allegations are cited at R240.</p> <p>Survey dates: May 19 and 20, 2015.</p> <p>Facility number: 0002999 Provider number: NA AIM number: NA</p> <p>Census bed type: Residential: 108 Total: 108</p> <p>Census payor type: Other: 108 Total: 108</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 000	<p><u>DISCLAIMER: "This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Hearth at Windermere as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community</u></p>	
-----------------------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R 055 Bldg. 00	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, interview, and record review, the facility to ensure a Resident's privacy was maintained when a Resident's eye drops were administered in a common area. (Resident #96)</p> <p>Findings include:</p> <p>During an observation, on 5/19/15 at 9:35 a.m., RN #5 was observed administering eye drops to Resident #96 in the activity room across from the dining room. There were 4 other residents in the room within the view of Resident #96.</p> <p>The MAR (medication administration record) for Resident #96 indicated Resident #96 received artificial tears in both eyes on 5/19/15 during the 9 o'clock hour, by RN #5.</p> <p>During an interview with the Director of Nursing (DON), on 5/20/15 at 1:28 p.m., she indicated Residents should have</p>			R 055	<p><u>or affiliated companies."</u></p> <p>1. The following corrective actions will be taken for Resident #96 - all appropriate staff will provide Resident #96 medications and treatments in a private location. 2. All residents have the potential to be affected by the deficient practice. 3. On duty nursing staff were immediately trained on the state regulations and Facility policies relating to the administration of eye drops, as well as resident rights regarding privacy. 4. The Director of Nursing will monitor monitor the administration of eye drops five times for one week, then three times weekly for two weeks, then weekly for three weeks. After 60 days the Director of Nursing will check two times per month for one year to assure continued compliance. 5. The date of completion will be June 15th.</p>		06/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R 240 Bldg. 00	<p>privacy when eye drops were administered.</p> <p>A policy titled, Eye Instillation, no date, was received from the DON on 5/20/15 at 2:22 p.m. The policy indicated, "...Explain procedure...Provide privacy...."</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's order for skin care/treatment and to safely transfer a resident in a manner necessary for their physical condition, for 4 of 5 residents whose clinical records were reviewed. (Resident #3 and Resident #'s A, B & C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 5/20/15 at 11:00 a.m. The diagnoses for Resident #3 included, but were not limited to, pressure wounds.</p> <p>The 3/30/15 Annual Assessment for Resident #3 indicated she required total assistance with dressing and would be completely assisted with dressing</p>	R 240	<p>1. On 5/20/2015 a new order was written, per physician, to apply bunny boots to Resident #3 at hs/remove in the am. This was added to the MAR for nursing to initial that they have checked placement and removal daily. 2. No other residents have been affected, but all residents could have potentially been affected. 3. On duty staff immediately received training on the state regulations and Facility policies on personal care services and assist with ADL's based on individual needs and preferences. 4. The Director of Nursing will check the MAR five times for one week to assure that nursing is signing off that they have verified placement or removal of bunny boots. The DON will then check the MAR three times weekly for two weeks, then one time weekly for three weeks. After 60 days,</p>	06/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE			STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>including encouragement, choice of clothing, and dressing. It indicated she was unable to participate in care at this point due to her decline, and that staff would dress her and change her as needed.</p> <p>The 5/11/15 Physician Telephone Order for Resident #3 indicated, "...Both heels skin prep daily. Leave open to air (symbol for "with") bunny boots (foot device used to pad the heel and prevent friction and shear)..."</p> <p>An observation was made on 5/20/15 at 12:10 p.m. of Resident #3 in the dining room in her wheelchair. She had slippers on her feet, not bunny boots.</p> <p>An observation was made with LPN #3 on 5/20/15 at 2:25 p.m. of Resident #3 in the activity room in her wheelchair. She had slippers on her feet, not bunny boots.</p> <p>An interview was conducted with LPN #3 on 5/20/15 at 2:26 p.m. She indicated the bunny boots were only to be worn at night. At this time, LPN #3 reviewed the 5/11/15 Physician Telephone Order for bunny boots and indicated Resident #3 should have bunny boots on.</p> <p>An observation of Resident #3's right heel was made with LPN #3 on 5/20/15</p>		<p>the DON will check the MAR three times monthly for one year or until the bunny boots are discontinued. 5. Date of completion will be June 15th, 2015 1. May 20th, 2015 -Nursing was provided gait belts for use in the safe transfer of Resident #C, as well as other dependent residents on both the KSV and AL unit. 2. No other residents have been affected, but all residents could have potentially been affected. 3. Two mandatory in-services were held for all nursing staff which covered transfers, lifting and the use of gait belts. These in-services included transfer of a dependent resident and two person transfers. Staff was also inserviced on the Facility policy on lifting/transfers. Staff were in-serviced on the importance of : (a) explaining the task/ procedure to the resident (b) locking the wheelchair and, (c) proper use of gait belts during the transfer of a dependent resident and two person transfers. 4. Transfers of dependent residents will be monitored five times a week for one week, then three times a week for two weeks, then one time weekly for three weeks. After 60 days, the Director of Nursing will monitor one time monthly for one year, asking staff to demonstrate the use of gait belts and two person transfers. All new nursing staff will be trained on the use of gait belts and two person</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>at 2:40 p.m. Her heel was dark red, dry, and scaly. At this time, LPN #3 indicated there was an open area on Resident #3's right heel previously, but it was now heeled.</p> <p>2. The clinical record for Resident #C was reviewed on 5/19/15 at 11:00 a.m. The diagnoses for Resident #C included, but were not limited to: Alzheimer's disease, lethargy, and physical deconditioning.</p> <p>An initial tour of the facility was conducted with LPN #3 on 5/19/15 at 10:20 a.m. During the tour, LPN #3 indicated Resident #C required 2 people for transfers and could not walk or stand.</p> <p>The 4/9/15 Admission Nursing Evaluation for Resident #C indicated she was dependent for transfers, ambulation, dressing, toilet use, and personal hygiene. It indicated she used a wheelchair as an assistive device. It indicated she was disoriented to time, place, and person, but knew her name.</p> <p>Resident #C's 5/1/15 Annual Assessment indicated she required total transfer assistance and would transfer safely with complete assistance.</p> <p>An observation of Resident #C was made</p>		transfers as part of their orientation on the floor. 5. Date of completion is June 15th, 2015.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>on 5/19/15 at 11:00 a.m. in the activity room. She was sitting in her wheelchair with both feet not on the foot pedals. CNA #2 bent down, lifted each of Resident #C's feet, and placed them on the foot pedals. Resident #C's head was leaning down and to the left.</p> <p>An observation of Resident #C being transferred from her wheelchair into bed by CNA #2 and QMA #1 was made on 5/19/15 at 1:18 p.m. Resident #C's wheelchair was next to her bed. The wheelchair brakes were not locked. CNA #2 hooked her arm underneath one armpit of Resident #C at the same time QMA #1 hooked her arm underneath the other armpit of Resident #C. They simultaneously lifted Resident #C from her wheelchair and transferred her into her bed. No gait belt was used during this transfer.</p> <p>An interview was conducted with Physical Therapist #4 on 5/20/15 at 9:57 a.m. He indicated, according to therapy standards, a (name of equipment used to transfer an individual) would be used if a resident was "dead weight", required 100% maximum assistance, and could not bear weight. He indicated, if a 2 person transfer was done properly, according to physical therapy standards, a gait belt would be used, the resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>would be engaged in the task, the armrest of the wheelchair would be raised, and the wheelchair must be locked. He also indicated he'd seen dislocated shoulders as a result of grabbing a resident under the arms.</p> <p>A policy, titled Lifting/Transfers, no date, was received from the Executive Director on 5/20/15 at 9:20 a.m. The policy indicated, "Purpose: To promote comfort, maintain good body alignment, decrease the complications related to immobility, decrease the possibility of injury to the resident...4. Transferring a Resident with injuries, pain or dementia can cause anxiety. The procedure should be done carefully while providing support and reassurance to the resident...6. To prevent accidents/injuries, the wheels of the bed and wheelchair must always be locked when transferring a resident....8. Explain procedure to resident before beginning....Two Person Assist Transfer....2. Place gait belt snugly around resident's waist, but loose enough to put two fingers between the belt and resident...4. Using one person's arm closest to the resident, securely grasp the gait belt...7. Count to three and lift together."3. The clinical record for Resident #B was reviewed on 5/19/15 at 11:11 a.m. The diagnoses for Resident #B included, but were not limited to,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>dementia, osteoarthritis, and gait abnormality.</p> <p>An observation of a wheelchair to bed transfer of Resident #B was done on 5/19/15 at 1:05 p.m. CNA #2 put Resident #B's wheelchair adjacent to Resident #B's bed. CNA #2 lowered Resident #B's bed. CNA #2 and QMA #1 lifted Resident #B under her arms, near her armpits, while LPN #3 moved the unlocked wheelchair away from the Resident. During the transfer, Resident #B drug her feet and did not bear any weight on her lower extremities, while CNA #2 and QMA #1 transferred Resident #B to her bed. During the entire observation of the transfer, the wheelchair remained unlocked and gait belts were not utilized. Neither CNA #2 nor QMA #1 explained the procedure or cued Resident #B during the transfer</p> <p>A [name of corporation] Assessment for Resident #B, dated 5/13/15, indicated to, "...staff remind resident to asist [sic] with standing and pivoting with transfers..."</p> <p>A policy, titled Lifting/Transfers, no date, was received from the Executive Director on 5/20/15 at 9:20 a.m. The policy indicated, "Purpose: To promote comfort, maintain good body alignment, decrease the complications related to immobility,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>decrease the possibility of injury to the resident...4. Transferring a Resident with injuries, pain or dementia can cause anxiety. The procedure should be done carefully while providing support and reassurance to the resident...6. To prevent accidents/injuries, the wheels of the bed and wheelchair must always be locked when transferring a resident...8. Explain procedure to resident before beginning....Two Person Assist Transfer....2. Place gait belt snugly around resident's waist, but loose enough to put two fingers between the belt and resident...4. Using one person's arm closest to the resident, securely grasp the gait belt...7. Count to three and lift together."</p> <p>An Inservice, titled ALL STAFF Lifting Inservice with [name of PT #4], dated 1/30/15, was received from the Executive Director on 5/20/15 at 9:15 a.m. The Inservice indicated, "...7...Gait belts are one way to keep a good grip on the client....Explain everything you are going to do-before you do it. Do this even if think the client can't hear or understand you...Don't grab a client by the armpits during a transfer...4. The clinical record for Resident #A on 5/19/15 at 11:22 a.m. The resident's diagnoses included, but were not limited to, Dementia of Alzheimer's type, hypertension, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>depression.</p> <p>On 5/19/15 at 1:38 p.m., during an observation, 2 staff members (CNA #6 and LPN #3) transferred Resident #A from a wheelchair to her bed. The resident was observed to not be able to assist with weight bearing during the transfer and the staff performed a majority of the physical weight bearing of the resident during the task. The staff members did not utilize a gait belt during the transfer and were observed placing their arms underneath both arms of the resident to lift the resident from the wheelchair to the bed.</p> <p>On 5/20/15 at 9:57 a.m., during an interview, Physical Therapist #4 indicated if a 2 person transfer was done properly, according to physical therapy standards, a gait belt would be used. He indicated the method of staff lifting a resident underneath the arms to lift them from a wheelchair was "not the recommended" technique to transfer a resident from a wheelchair to bed.</p> <p>A policy, titled Lifting/Transfers, no date, was received from the Executive Director on 5/20/15 at 9:20 a.m. The policy indicated, "Purpose: To promote comfort, maintain good body alignment, decrease the complications related to immobility,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 349 Bldg. 00	<p>decrease the possibility of injury to the resident...4. Transferring a Resident with injuries, pain or dementia can cause anxiety. The procedure should be done carefully while providing support and reassurance to the resident...6. To prevent accidents/injuries, the wheels of the bed and wheelchair must always be locked when transferring a resident...8. Explain procedure to resident before beginning....Two Person Assist Transfer....2. Place gait belt snugly around resident's waist, but loose enough to put two fingers between the belt and resident...4. Using one person's arm closest to the resident, securely grasp the gait belt...7. Count to three and lift together."</p> <p>This State Tag relates to Complaint IN00173810.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, interview, and</p>	R 349	1. The resident care plan for	06/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2015	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>record review, the facility failed to ensure a Resident's clinical record was accurate for 1 of 5 clinical records reviewed (Resident #B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/19/15 at 11:11 a.m. The diagnoses for Resident #B included, but were not limited to, dementia, osteoarthritis, atrial fibrillation, and gait abnormality.</p> <p>During an observation of a wheelchair to bed transfer of Resident #B with QMA#1 and CNA #2, on 5/19/15 at 1:05 p.m., Resident #B was unable to bear any weight on her lower extremities during the transfer.</p> <p>A Progress Note, dated 2/25/15, indicated Resident #B was, "...total care. cann't [sic] put any wt [weight] on her feet...."</p> <p>A Progress Note, dated 3/20/15, indicated, "...She is un able [sic] to stand up, so 2 person assist...."</p> <p>A Progress Note, dated 4/19/15, indicated, "...Difficult to bear weight due to joint pain, gait abnor mality [sic]...."</p> <p>A [name of corporation] Assessment,</p>		<p>Resident#8 was immediately corrected to reflect the resident's non-weight bearing status under the section listed as "ambulation/escort/mobility"to reflect dependency with transfers. 2. No other residents have been affected, but all residents potentially could have been. 3. All nursing staff will be in-serviced on the Facility policy on Care Plans. An audit of all resident charts was completed to ensure that each resident care plan reflects their weight-bearing ability/transfer assist needs correctly. 4. The Director of Nursing will review each quarterly Care Plan for accuracy, prior to meeting with the family/ resident. The Care Plan will be updated with any changes on an ongoing basis. 5. The date of completion is June 15, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>dated 5/13/15, indicated Resident #B was full weight bearing in the "Ambulation/Escort/Mobility" section.</p> <p>During an interview with the the Director of Nursing (DON), on 5/20/15 at 1:28 p.m., the DON indicated the [name of corporation] Assessment was used as the facility assessment and care plan for Residents and Resident #B's Assessment was inaccurate.</p> <p>A policy titled, Care Plans (Resident Care Planning), no date, was received from the DON, on 5/20/15 at 2:43 p.m. The policy indicated, "Purpose: To promote individualized resident care plans, with specific plans from nursing and other disciplines. To provide for continuity of care...To provide guidelines for nursing assignments....The care plan is the primary communication tool and should be a composite picture of the resident and all care to be given...."</p>			